MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 (2)

CERTIFICATE OF DEATH

01390

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Marylahd County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 236 North Locust Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Julia Lula Baker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Ernest M. Baker
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mrach 6, 1886

8. AGE: Years	Months	Days	If less than one day
61	1	4	..... hrs. ..... min.

9. Birthplace: Franklin Co. Penna.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business:

FATHER
12. Name: Wilken B. Mowen
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Shaffer
15. Birthplace: Maryland

16. Informant: Mrs. Alice Kittell
Address: Hagerstown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Maryland

19. Apr. 12. 1947 (Date rec'd by registrar) Chas. H. Boevers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1947 at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1946 to April 10 1947 and that I last saw h. alive on April 9th 1947

Immediate cause of death	DURATION
Carcinoma - Sigmoid Colon	6 mo.
Due to:	
Due to:	
Other conditions: Intestinal Obstruction	8 days.
Gangrene - Ileum	6 days.

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma - Sigmoid Colon
Date of op. 8/31/47
Autopsy results: Gangrene - Ileum - Intest. Obstruction
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of: .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. H. Boevers M.D. M. D. or other
Address: 159 W. Washington St Date signed: 4/11/47

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Dr. Blessing 75

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
733 Virginia Ave
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 733 Virginia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MRS. LAURA BELLE BARGER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Rev William D. Barger
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): June 16, 1856

8. AGE: Years	Months	Days	If less than one day
90	9	25	-- hrs. -- min.

9. Birthplace: Centersville, Tyler Co. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Peter Smith
13. Birthplace: Centersville Va.
MOTHER 14. Maiden name: Mary Ripley
15. Birthplace: Ripley, West Virgina
16. Informant: Miss Bessie Barger
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/14/47 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
16. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19 Apr. 11. 19 47 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947 19..., at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1946, to April 10 1947 and that I last saw h[illegible] alive on April 10 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to Endocarditis	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Arthur L Blessing M.D. M. D. or other
Address: Boonsboro Md Date signed April 10 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Diet. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: (Rural) Harpers Ferry, W. Va. R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Norman Harry Barrett

3.(b) Social Security Number: Unavailable

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Mary Ellen Barrett
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1901

8. AGE: Years: 46 Months: 0 Days: 21 If less than one day: hrs. min.

9. Birthplace: Washington County, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Foundry

FATHER
12. Name: John William Barrett
13. Birthplace: Jefferson County, West Va.

MOTHER
14. Maiden name: Amanda Frances Johnson
15. Birthplace: Washington County, Maryland

16. Informant: Mrs. Mary E. Barrett
Address: R.F.D. #1, Harpers Ferry, West Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1 1947 (month) (day) (year)
Cemetery or crematory: Samples Manor Cemetery
Location: Samples Manor, Md.

18. Funeral director: Freeland F. Flinder
Address: Charles Town, West Va.

19. Apr 28, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1947, at 8:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20, 1947, to April 28, 1947 and that I last saw him alive on April 27, 1947

Immediate cause of death	DURATION
Hypertensive, cardio-vascular renal disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry Aldis M.D. M. D. or other
Address: Shepherdstown, W. Va. Date signed: 4/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 30 1947
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

01393

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Cascade
(If outside city or town limits, write RURAL and give nearest town)
Street No. ------
(If rural, give LOCATION)
2.(a) If veteran, name war ------

3.(a) FULL NAME: Naomi Ruth Beckner

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Oliver Grayson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 18, 1889

8. AGE: Years	Months	Days	If less than one day
57	11	25	..... hrs. ..... min.

9. Birthplace: Fayetteville Frank. Pa,
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Sol Sollenberger
13. Birthplace: Fayetteville Pa.

MOTHER
14. Maiden name: Annie Fahrney
15. Birthplace: Unknown

16. Informant: Benjamine F. Stouffer
Address: Cascade Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-17-47 (month) (day) (year)
Cemetery or crematory: Quincy Cemetery
Location: Quincy Pa,

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. Apr. 17, 1947 (Date rec'd by registrar) Ethel H. Beaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1947, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11, 1947 to April 13, 1947
and that I last saw her alive on April 13, 1947

Immediate cause of death	DURATION
Myocardial dilitation	4/13/47
Due to: Myocarditis Chr	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. H. Porterfield M.D. M. D. or other
Address: 136 W Washington Date signed 4/16/47

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16

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01394

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? Few Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 333 South Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William H. Bradley

3.(b) Social Security Number: 219-01-7931

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katie M. Bradley

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): April 10, 1885

8. AGE: Years	Months	Days	If less than one day
62	0	0	...hrs. ...min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Painter (Retired)

11. Industry or business:

FATHER
12. Name: Bradley
13. Birthplace: Philadelphia, Pa.

MOTHER
14. Maiden name: Margaret Snyder
15. Birthplace: Philadelphia, Pa.

16. Informant: Mrs. William H. Bradley
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Apr. 12, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/11/47, 19..., at 6:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/10/47, 19..., to 4/11/47, 19...; and that I last saw h... alive on 4/11/47, 19...

Immediate cause of death	DURATION
Coronary Occlusion	1 Day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C. L. Gorsuch M. D. or other

Address: 6 W. Church St. Hagerstown Md. Date signed 4/11/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

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APR 15 1947
BUREAU OF

Dr. Victor Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

01395

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, institution, or street address where death occurred:
Layman Nursing Home
How long in hospital or institution? 3 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 319 Liberty St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: WILLIAM EDWARD BRINKLEY

3.(b) Social Security Number: 705-12-7383

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Barrow Brinkley
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): April 29, 1908

8. AGE: Years	Months	Days	If less than one day
38	11	11	-- hrs. -- min.

9. Birthplace: Mercersburg Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation: Baker
11. Industry or business: Caskey Baking Co.
FATHER 12. Name: Harry Brinkley
13. Birthplace: Mercersburg Pa.
MOTHER 14. Maiden name: Irene Brinkley
15. Birthplace: Mercersburg Pa.
16. Informant: Mrs. Virginia B. Brinkley
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/47 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
16. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
16. Apr. 9, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1947, at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 21 1947, to Mar 21 1947
and that I last saw h[illegible] alive on Mar 21 1947

Immediate cause of death	DURATION
Carcinoma of lung	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Date signed 4-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MAY 6 1947
BUREAU

Dr. Wells

01396

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 954

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
1098 Viginia Ave.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residences of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1098 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME
MRS. SARAH MARGARET BUSICK

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William
6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 1, 1866

8. AGE: Years	Months	Days	If less than one day
81	1	26	-- hrs. -- min.

9. Birthplace Cripple Creek, Wythe Co. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Absolom Hines
13. Birthplace Cripple Creek Va.

MOTHER
14. Maiden name Lucinda Davis
15. Birthplace Cripple Creek Va.

16. Informant Mrs. J. S. Crockett
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/29/47 (month) (day) (year)
Cemetery or crematory St. Peters Cemetery
Location Cripple Creek Va.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. apr 28, 47 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 45 to Apr/27/47 and that I last saw her alive on April /27/47

	DURATION
Immediate cause of death	
Chr. myocarditis	6yrs
Due to auricular fibrillation	4yrs
Due to acute vetricular fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. Robert Wells M. D.
M. D. or Coroner
Address Hagerstown, Md. Date signed 4/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3 01307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: William Gardner Bussard

3.(b) Social Security Number: 219-13-6416

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12,1903

8. AGE: Years 44 | Months 1 | Days 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Sharpsburg-Wash.-Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Pangborn Corp.-Hagerstown, Md

FATHER 12. Name: Franklin Bussard

13. Birthplace: Sharpsburg, Md

MOTHER 14. Maiden name: Annie Morrison

15. Birthplace: Locust Grove-Md

16. Informant: Mrs. Annie Bussard

Address: Sharpsburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19,1947 (month) (day) (year)

Cemetery or crematory: Luthuran

Location: Locust Grove-Md.

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md

19. 4/18/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (Month) Sept. 1 1946 to (Month) April 16 1947

and that I last saw h... alive on (Month) April 16 1947

Immediate cause of death

Cardio-vascular Syphilis
(Patient found dead in bed)

DURATION: 7.

Due to: (sudden heart attack)

Due to

Other conditions: General paresis. DURATION: 7.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Walter H. Shealy M.D.
M. D. or other

Address: Sharpsburg, Md. Date signed 4/17/47

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APR 23 1947
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Dr. Wells 01398 39

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-1)

CERTIFICATE OF DEATH

Reg. Diat. No. 300

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Weeks
Hospital, institution, or street address where death occurred:
Sherman Ave
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sherman Ave
(If rural, give LOCATION)
2.(a) If veteran, name war --

3.(a) FULL NAME: Rita Sue Butts

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife --
6.(c) If alive, give age --

7. Birth date of deceased (mo., day, yr.) March 21 1947

8. AGE: Years	Months	Days	If less than one day
-	1	8	...hrs. ...min.

9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Infant
11. Industry or business -

FATHER
12. Name Melvin A. Butts
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden name Bettie A. Semler
15. Birthplace Taylors Landing Md.

16. Informant Melvin A. Butts
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/1/47 (month) (day) (year)
Cemetery or crematory Mt. View Cemetery
Location Sharpsburg Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. April 30 1947 (Date rec'd by registrar) C. Kraft Bowers Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 29 1947 19... at 6.00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Suffocation by aspiration of vomitus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None ...Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4/29/47
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Aspirated vomitus ed at work? No

23. SIGNATURE: R. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.
Address Hagerstown, Md. Date signed 4/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
MAY 2 1947
BUREAU OF

24

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Ralph Yontz 399

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred:
Washington county Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 834 Georgia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MRS FLORENCE REBECCA CATLETT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Famale	white	widow

6.(b) Name of husband or wife: Geargе
6.(c) If alive, give age: -

7. Birth date of deceased (mo., day, yr.): September 25 1868

8. AGE: Years	Months	Days	If less than one day
78	6	19	...hrs. ...min.

9. Birthplace: Charlestown Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: John R. Reed
13. Birthplace: Mercersburg Pa.

MOTHER
14. Maiden name: Margaret Reed
15. Birthplace: Mercersburg Pa.

16. Informant: Benjamin Gift
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/47 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. apr. 16. 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947, at 7 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/13/47 to 4/14/47 and that I last saw h. alive on 4/14/47

	DURATION
Immediate cause of death: Coronary Occlusion	1 Day
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: C. F. Young, M. D. or other
Address: Williamsport Md. Date signed 4/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 18 1947
BUREAU OF

Dr. Podlesny 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ Years

Hospital, institution, or street address where death occurred:
Washington County Home

How long in hospital or institution? 1½ Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Broadway Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Miss Mary Louise Coxell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.): May 12, 1867

8. AGE: Years	Months	Days	If less than one day
79	8	22	-- hrs. -- min.

9. Birthplace: Reading, Berks Co. Pennsylvania
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own Home

FATHER
12. Name: William Coxell
13. Birthplace: Reading Pa.

MOTHER
14. Maiden name: Sarah Grauh
15. Birthplace: Reading Pa.

16. Informant: William A. Tobias
Address: Hagerstown Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/7/47 (month) (day) (year)

Cemetery or crematory: Charles Evans Cemetery

Location: Reading Penna.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. apr. 4, 1947 (Date rec'd by registrar) Elsie H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4, 1947, at 5 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 15 1947 to Apr. 4 1947 and that I last saw her alive on Apr. 2 1947

Immediate cause of death	DURATION
Due to: Thrombosis deep femoral right leg.	3 Wks
Due to: Gangrene right foot.	1 wk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ernest F. Poole M.D. M. D. or other

Address: Hagerstown, Md. Date signed 4/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 7 1947
BUREAU OF S.

1-58

21

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119

01401

CERTIFICATE OF DEATH

Reg. Dist. No. 30-2

1. PLACE OF DEATH:
County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours
Hospital, institution, or street address where death occurred: Washington Co. Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Frederick
City or town Rural - Myersville (If outside city or town limits, write RURAL and give nearest town)
Street No. Pleasant Walk (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Richard Dagenhart Jr

3. (b) Social Security Number ——

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) Feb 10 - 1947

8. AGE: Years — Months 1 Days 29 If less than one day ...... hrs. ...... min.

9. Birthplace Nr. Myersville Fred. Co. Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business Mother - Housewife

FATHER
12. Name Richard Dagenhart Sr
13. Birthplace Myersville Md

MOTHER
14. Maiden name Kathleen Lewis
15. Birthplace Myersville, Md

16. Informant Kathleen Dagenhart
Address Myersville, Md

17. Burial Date thereof April 11, 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pleasant Walk
Location Nr Myersville Md

18. Funeral director Paul F. Bittle
Address Myersville, Md

19. April 11, 1947 Chas H Biser (Date rec'd by registrar) Registrar
Burial Permit issued by [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1947, to April 9 1947
and that I last saw him alive on April 9 1947

Immediate cause of death Malnutrition.
Due to Gastroenteritis in final stage [6/25/47 akc]
119a.2
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ...... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ...... Injured at work?

23. SIGNATURE G. W. Way M.D. M. D. or other
Address Boonsboro. Date signed 4/9/47

RECEIVED
APR 16 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

01402

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
144 So. Locust St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County:
City or town: Carlisle
(If outside city or town limits, write RURAL and give nearest town)
Street No. 346 East Souther St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertie Jane Ditzler (Ditzler)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Irvin Ditzler

7. Birth date of deceased (mo., day, yr.): Mar. 22, 1862 — 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
85		17	hrs. min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER — 12. Name: unknown — 13. Birthplace: unknown
MOTHER — 14. Maiden name: unknown — 15. Birthplace: unknown
16. Informant: Charles A. Brown
Address: 144 So. Locust St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Carlisle, Pa.
18. Funeral director: Suitz & Son
Address: Carlisle, Pa.
19. Apr. 9, 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1947, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Vascular arteriosclerosis	
Due to: Chr. myocarditis	
Due to: Coronary occlusion	2wks
Due to: Hypostatic pneumonia	10 d.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NO
Date of op.:
Autopsy results: NO
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.
Address: Hagerstown Md. Date signed: Apr. 8 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

Chas. H. Bowers
928 Mulberry Ave.

RECEIVED
APR 11 1947

14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

01403

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4years
Hospital, institution, or street address where death occurred: 129 Alexander St Hagerstown Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 129 Alexander Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James William Dodd

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margret Bowser Dodd
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 25 1853 1853

8. AGE:

Years	Months	Days	If less than one day
93	5	15	..... hrs. ..... min.

9. Birthplace: Williamsport Md
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Canning Co Cumberland
FATHER 12. Name: Issac Dodd
13. Birthplace: Newyork State
MOTHER 14. Maiden name: dont Know Spear
15. Birthplace: Dont Know
16. Informant: Wilson Dodd
Address: Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11 1947 (month) (day) (year)
Cemetery or crematory: Riverview Cem
Location: Williamsport Md
18. Funeral director: Edith V. Leaf
Address: Williamsport Md
19. Apr. 10. 1947 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 9 1947, at 3 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Apr 9 1947
and that I last saw h.. alive on Apr 6 1947

Immediate cause of death	DURATION
Chr. Myocarditis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D.
M. D. or other
Address: Hagerstown, Md. Date signed 4-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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APR 12 1947
BUREAU

17

01404

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 79-2

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Bridgeport - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months.
Hospital, Institution, or street address where death occurred: Hagerstown Md. R.1
How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Bridgeport (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Md. R.1
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Eliza Kate Emmert

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Norman L. Emmert
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April - 16 - 1876

8. AGE: Years: 70 | Months: 11 | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bakersville Washington Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home.

FATHER
12. Name: Josiah Ellsworth Davis
13. Birthplace: Bakersville Washington Co. Md.

MOTHER
14. Maiden name: Sarah Small
15. Birthplace: Beddington W. Va.

16. Informant: Mrs. Norman L. Emmert
Address: Hagerstown Md. R.1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13, 1947 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: near Beldington Md.

16. Funeral director: Chas. H. Bast & Sons
Address: Boonsboro, Md.

19. Apr. 12. 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1946 to April 10 1947 and that I last saw h.. alive on April 10 1947

	DURATION
Immediate cause of death: Myocarditis Chronic.	4
Due to:	
Due to: Arteria Sclerosis.	2 Years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Williamsport Md. Date signed: 4/12/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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APR 15 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

01405

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 237 Cushwa Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lola Estella Fearnow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife C. Curtis Fearnow
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 26 1893

8. AGE: Years	Months	Days	If less than one day
54	4	14	...hrs. ...min.

9. Birthplace Hagerstown R.F.D. #2 Wash. Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name Harvey A. Myers
13. Birthplace Maryland

MOTHER
14. Maiden name Annie V. Wolf
15. Birthplace Pa;

16. Informant C. Curtis Fearnow
Address Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13 1947 (month) (day) (year)
Cemetery or crematory Greenlawn Cem
Location Williamsport Md.
18. Funeral director Edith V. Leaf
Address Williamsport Md

19. April 13 19 47 (Date rec'd by registrar) E. Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 47 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1945 19.. to April 9 19 47 and that I last saw h.. alive on April 7 19 47

Immediate cause of death	DURATION
Carcinoma of Rectum	
Due to Following Hysterectomy	about 10 years
Due to Ago	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Williamsport Md Date signed 4/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

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APR 15 1947
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01406 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One day
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Sharpsburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John William Fisher, Jr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bessie Snavely McGraw
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1866

8. AGE: Years	Months	Days	If less than one day
81	6	18	..... hrs. ..... min.

9. Birthplace: Sharpsburg, Washington, Md. (Town, county, and state)
10. Usual occupation: Tool Room Attendant
11. Industry or business: Western Maryland Railroad

FATHER
12. Name: John William Fisher, Sr.
13. Birthplace: Vicinity of Sharpsburg, Md.

MOTHER
14. Maiden name: Helen Himes
15. Birthplace: Vicinity of Sharpsburg, Md.

16. Informant: Iva H. Moore
Address: 409 Fairview Ave. Frederick, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 7 1947 (month) (day) (year)
Cemetery or crematory: Mountain View Cemetery
Location: Sharpsburg, Maryland

18. Funeral director: Mrs. Edith V. Leaf
Address: Williamsport, Maryland.

19. Apr. 7, 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1947, at 9:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947 to April 4 1947 and that I last saw h... alive on April 4 1947

Immediate cause of death	DURATION
(a) Coronary Thrombosis.	24 hours
Due to: (b) Cardio-Vascular disease	4 yrs.
Due to: (c)	
Other conditions: Benign Hypertrophy of Prostate	2 years

(Include pregnancy within 3 months of death)

Major findings of operations: Benign Hypertrophy Prostate Electro-Surgical resection Date of op. 3/14/47
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Walter H. Sheads M.D. M. D. or other
Address: Sharpsburg, Md. Date signed: 4/6/47

RECEIVED
APR 9 1947
BUREAU

Dr. Wells 34

01407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, institution, or street address where death occurred:
143 S. Mulberry St.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 143 S. Mulberry Stl
(If rural, give LOCATION)
2.(a) If veteran, name war ~~None~~ W.W.I

3.(a) FULL NAME
Harry Godlove

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) November 19, 1886

8. AGE: Years	Months	Days	If less than one day
60	5	10	-- hrs. -- min.

9. Birthplace Capon Bridge Hampshire Co. W. Va.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name John A. Godlove
13. Birthplace Wardensville W. Va.

MOTHER
14. Maiden name Mary Bauserman
15. Birthplace Ceder Creek Va.

16. Informant Mrs. Harry Gordon
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/27/47 (month) (day) (year)
Cemetery or crematory Mt. Hebron Cemetery
Location Winchester Va.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. Apr. 26. 19 47 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 19 47 at 6:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute coronary occlusion	6 hrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation No Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNED J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or other
Address Hagerstown, Md. Date signed 4/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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APR 29 1947
BUREAU OF S.

Birth and Death 014118 5

MARYLAND STATE DEPARTMENT OF HEALTH (160-2)

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution: Washington County Hospital

Length of mother's stay in County

(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Washington

City or town Clewsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If RURAL give LOCATION)

3. Name of child Baby Hamburg

4. Date of birth April 24 1947 Hour 8:30 A.M.

5. Sex Male. | 6. Twin or triplet

7. No. of weeks pregnancy 24

FATHER OF CHILD

8. Full name Donald Edward Hamburg

9. Color White 10. Age at time of this birth 34 yrs.

11. Usual occupation Fairchild aircraft

MOTHER OF CHILD

12. Full maiden name Thelma Irene Longnecker

13. Color White 14. Age at time of this birth 29 yrs.

15. Usual occupation

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1

(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of

1. Membrane Rupture at 20 wks.
1. Uterine inertia.

19. Labor: (a) Complications of —

(b) Induced? 0

20. (a) Was there an operation for delivery? YES. (Yes or No)

(b) State all operations, if any

Caesarean Section

(c) Did child die before operation? no

During operation? no.

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes —

(b) Maternal causes —

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature B. B. Schneider M.D.

(Specify if M. D., midwife, or other)

Address 148 W. Wash. St. Hagerstown Md.

23. (a) Burial (b) Date thereof Apr 25 47 (month) (day) (year)

(Burial, cremation or removal)

(c) Cemetery or crematory Sm Hamburg

24. (a) Funeral director C. M. Sechrist & Son

(b) Address Hagerstown

25. (a) Apr. 25 1947 (b) C. Grant Howard

(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

V. S. A10

(OVER)

Child lived 5 hours

A detailed Summary of this case can be furnished if desired. The mother's membranes definitely ruptured at 30 wks gestation period. She was kept at home at absolute rest in bed, but no indications occurred at spontaneous abortion. She was removed to hospital and medical induction was tried several times with no results. The cervix was intact & had closed & fetal heart sounds were well heard room just 15 min. previous to section. Pt. was given penicillin intramuscularly during her hospital stay previous to section. Elective section was selected as best for mother because of uterine inertia with ruptured membranes, & because of possible infection occurring from below if held longer. The baby cried shortly after birth - no long attempts at resuscitation were made, but was given oxygen & put under immediate care of pediatrician.

Apr. 28 47.

A. P. Chesley M.D.

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APR 28 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

01409

2411 N. Charles St., Baltimore 93-A

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsport Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 S. Conocheague
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie Harsh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John Harsh
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19 1871

8. AGE: Years	Months	Days	If less than one day
75	7	26	hrs. min.

8. Birthplace Williamsport Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife
11. Industry or business home

FATHER
12. Name Harry Newcomer
13. Birthplace Fairplay Md.

MOTHER
14. Maiden name Emma Ardinger
15. Birthplace Williamsport Md

16. Informant Rachel Gaylor
Address Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18 1947 (month) (day) (year)
Cemetery or crematory Greenlawn Cem
Location Williamsport MD

18. Funeral director Edith V. Leaf
Address Williamsport Md

April 18 47 (Date rec'd by registrar) E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 47, at 12 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 47 to April 15 19 47
and that I last saw h alive on April 15 19 47

Immediate cause of death Cerebral hemorrhage — DURATION 4 days
Due to Cerebral Sclerosis — 4 years
Due to
Other conditions Myocardial Decay — 4 yrs
(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Williamsport Md Date signed 4/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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APR 22 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01410 Reg. Dist. No. 304

1. PLACE OF DEATH:
County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. East Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME George Carl Huber

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Cora Smith Huber
6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	15	— hrs. — min.

9. Birthplace Chambersburg, Franklin Co., Penna (Town, county, and state)
10. Usual occupation Printer
11. Industry or business Publisher
FATHER 12. Name Theodore Huber
13. Birthplace Penna.
MOTHER 14. Maiden name Catherine Garner
15. Birthplace Penna.
16. Informant Mrs. Cora S. Huber
Address E. Main St., Hancock, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1947 (month) (day) (year)
Cemetery or ~~crematory~~ St. Thomas Episcopal
Location Hancock, Md.
18. Funeral director Charles R. Bast
Address Hancock, Md.
19. 4-21-47 (Date rec'd by registrar) J. A. Heller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1947, at 5 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18 1947, to 4-18 1947
and that I last saw h~~im~~ alive on 4-18 1947

Immediate cause of death	DURATION
Rectal Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herbert R. Tobias M.D. M. D. or other
Address Hancock Md. Date signed 4-19-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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APR 23 1947
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5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-C)

CERTIFICATE OF DEATH

01411

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1day
Hospital, Institution, or street address where death occurred: Nursing Home- 241 S. Prospect St.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY E. KERSHNER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Cyrus E. Kershner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1870

8. AGE: Years	Months	Days	If less than one day
77	2	19	hrs. min.

9. Birthplace: Clear Spring- Wash. Md. (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business

FATHER
12. Name: Alexander Mullen
13. Birthplace: Cumberland Co., Pa.

MOTHER
14. Maiden name: Mary E. Staley
15. Birthplace: Wash. Co., Md.

16. Informant: George A. Mullen
Address: Clear Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 5, 1947 (month) (day) (year)
Cemetery or crematory: St. Paul's Cemetery
Location: Clear Spring Route 40 E

18. Funeral director: Snyder-Rowland Funeral Home
Address: Clear Spring, Md.

19. Apr. 5, 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1947 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 12, 1947, to Apr. 2, 1947
and that I last saw h... alive on April 1, 1947

Immediate cause of death ... DURATION

	DURATION
Acute Endocarditis	3 weeks
Cerebral Hemorrhage	4 days
Due to Arterio Sclerosis	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: David R. Brewer M. D
M. D. or other
Address: Clear Spring Md. Date signed: 4/4/47

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APR 8 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45.21

CERTIFICATE OF DEATH

S 01412

Reg. Dist. No. 203

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: WASHINGTON

City or town: CANOCOCHEAGUE (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, Institution, or street address where death occurred: GATE WAY NURSING HOME

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: PENNSYLVANIA County: FRANKLIN

City or town: FAYETTEVILLE (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: AMOS BENJAMIN LEHMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: MARY C. LEHMAN

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): SEPT. 9, 1859

8. AGE: Years	Months	Days	If less than one day
87	7	12	..... hrs. ..... min.

9. Birthplace: FAYETTEVILLE, PA. (Town, county, and state)

10. Usual occupation: RETIRED FARMER

11. Industry or business

FATHER — 12. Name: SAMUEL B. LEHMAN

FATHER — 13. Birthplace: FRANKLIN Co. PA.

MOTHER — 14. Maiden name: NOT KNOWN

MOTHER — 15. Birthplace: FRANKLIN Co. PA

16. Informant: P. B. Lehman

Address: Chambersburg Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: APR 23 1947 (month) (day) (year)

Cemetery or crematory: COVANENTER CEM.

Location: FAYETTEVILLE, PA

18. Funeral director: Robert Sellers

Address: Chambersburg Pa

19. April 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 21 1947 and that I last saw h[illegible] alive on April 21 1947

Immediate cause of death	DURATION
Carcinoma of	
lip (Lower)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Aubrey Nowerstern M.D. M. D. or other

Address: Fayetteville Pa Date signed 4/22/47

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MAY 6 1947
BUREAU

Dr. Wells 30

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (700)

CERTIFICATE OF DEATH

MV 01413

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1/2 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clear Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: JAMES WILLIAM LEROY LONG

3.(b) Social Security Number: 219-05-2608

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gladys Long

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): October 30, 1916

8. AGE: Years	Months	Days	If less than one day
30	5	19	-- hrs. -- min.

9. Birthplace: Clear Spring, Washington Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Coppers Co. Wood Preserving Co.

FATHER — 12. Name: John Long

FATHER — 13. Birthplace: Big Spring Md.

MOTHER — 14. Maiden name: Lucy May Hart

MOTHER — 15. Birthplace: Green Spring Md.

16. Informant: Gladys Long

Address: Clearspring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/22/47 (month) (day) (year)

Cemetery or crematory: Green Spring Cemetery

Location: Green Spring Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Apr 21 1947 (Date rec'd by registrar) Chas H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 9 1947 to Apr 19 1947 and that I last saw h... alive on Apr 9 1947

Immediate cause of death: Fracture of Skull — DURATION: 10 min

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of Apr 9 1947

Where did injury occur? R.F.D. Hagerstown Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of injury: Automobile Injured at work? No

23. SIGNATURE: H. Beadle M.D. M. D. or other

Address: Hagerstown Md Date signed: 4/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 23 1947
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40

Dr. Hirshman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

Reg. Diat. No. 01414 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ Years
Hospital, institution, or street address where death occurred:
310 West Side Ave.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 West Side Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: MRS. BESSIE GEEDY MARQUART

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White,	Married

6.(b) Name of husband or wife: George H. Marquart
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1885

8. AGE: Years	Months	Days	If less than one day
61	7	10	--hrs. --min.

9. Birthplace: Newville, Cumberland Co. ~~Md.~~ Pa
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home

FATHER
12. Name: George H. Geedy
13. Birthplace: Newville ~~Md.~~ Pa

MOTHER
14. Maiden name: Matilda Deene
15. Birthplace: Newville ~~Md.~~ Pa

16. Informant: George H. Marquart
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/47 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Apr. 30, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1947, at 1:45 M

21. I CERTIFY that death occurred on the date above etated; that I attended deceased from May 17 1946 to April 28 1947 and that I last saw her alive on April 28 1947

	DURATION
Immediate cause of death: Chronic Nephritis	1 yr.
Due to: Hypertension	1 yr.
Due to:	
Other conditions: Diabetes Mellitus.	9 yrs.
Uremia	1 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Philip J. Hirshman MD M. D. or C. M.
Address: 15 W. Washington St Date signed: 4/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
MAY 2 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01415

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Cearfoss, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
Cearfoss
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Cearfoss
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cearfoss
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Alice Martin

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1863

8. AGE: Years	Months	Days	If less than one day
83	4	3	hrs. min.

9. Birthplace: Washington Co. Md.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business

FATHER
12. Name: David Martin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary A. Bell
15. Birthplace: Maryland

16. Informant: Cyrus D. Bell
Address: Williamsport, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Maryland.

19. Apr. 30 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1947 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-40 19.. to 4-28- 1947
and that I last saw h.. alive on 4-26-47 19..

Immediate cause of death	DURATION
Senility a general	10 yrs
Due to: Arter-sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: Hagerstown Md Date signed: 4/30/47

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
MAY 2 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01416

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington

City or town Mt. Lena 'Rural'
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2.

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Mt. Lena. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Emma Virginia Marty.

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William Marty.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June - 25 - 1866

8. AGE: Years	Months	Days	If less than one day
80	10	3	..... hrs. ..... min.

9. Birthplace Mt. Lena Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housekeeper.

11. Industry or business Own Home.

FATHER
12. Name James Saulders.
13. Birthplace Wash. Co. Md.

MOTHER
14. Maiden name Amelia Snyder.
15. Birthplace Wash. Co. Md.

16. Informant Roy C. Marty.
Address Boonsboro Md. R. 2.

17. Burial (Burial, cremation, or removal, Which?) Date thereof April - 30 - 1947 (month) (day) (year)

Cemetery or crematory Zahniser's Cemetery

Location near Mapleville Md.

18. Funeral director Wm. D. Bast & Son

Address Boonsboro Md.

19. April 30, 1947 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28" 1947 at 6.30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 - 1946 to April 28" 1947

and that I last saw h... alive on Sept. 23 1946

Immediate cause of death Chronic Nephritis — DURATION 7 Mos. 5 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Leland Rader M.D.
M. D. or other

Address Boonsboro Md. Date signed 4/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

RECEIVED
MAY 2 1947
BUREAU V 8

Dr. wells 32

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

01417

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
Main St.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MRS. ORA MAY BINKLEY McCOY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stanley
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): December 20 1889

8. AGE: Years	Months	Days	If less than one day
57	4	3	...hrs. ...min.

9. Birthplace: Leitersburg Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Daniel Binkley
13. Birthplace: Leitersburg Md
MOTHER 14. Maiden name: Eva Elizabeth Downin
15. Birthplace: Hagerstown Md.
16. Informant: Stanley McCoy
Address: Maugansville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/25/47 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Apr 25, 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1947 about 8A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
suffocation drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date: 4/23/47
Where did injury occur? Maugansville (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: drown self in bath tub Injured at work?

DEPUTY MEDICAL EXAM. WASH. CO., MD.
23. SIGNATURE: H. Hunt Wells M. D. or
Address: Hagerstown, Md. Date signed: 4/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
APR 28 1947
BUREAU V R

22

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01418

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON CO.

City or town HAGERSTOWN, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
WASHINGTON COUNTY HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 21 days

Stay in this community (yrs., or mos., or days) 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND Dist. County WASHINGTON

City or town HAGERSTOWN Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 146 N. JONATHAN St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
CHARLOTTE ELIZABETH MILLER

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	NEGRO	WIDOWED.

6 (b) Name of husband or wife ELLSWORTH MILLER
(Deceased) 6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) AUG. 5, 1900.

8. AGE: Years	Months	Days	If less than one day
46	8	10	____ hrs. ____ min.

9. Birthplace Mercersburg, Pa.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Robert Stover

13. Birthplace Mercersburg, Pa.

MOTHER 14. Maiden name Mary E. Watson

15. Birthplace Mercersburg Pa.

16. Informant Robert V. Burk

Address Mercersburg, Pa. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/47. (month) (day) (year)

Cemetery or crematory Zion Union Cem.

Location Mercersburg, Pa.

18. Funeral director J. M. Lehninger

Address Mercersburg Pa.

19. Apr. 16. 19 47 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 APRIL 1947 19 ____, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 MARCH 1947, to 15 APRIL 1947, and that I last saw her alive on 15 APRIL 1947.

Immediate cause of death	DURATION
CARCINOMATOSIS	6 MO
Due to METASTESIS TO LUNGS AND PELVIC	?
Due to VISCERA FROM CARCINOMA OF UTERUS	
Other conditions (CORPUS AND CERVIX)	3 DAYS
UREMIA	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. D. Laymon, M.D.
M. D. or other

Address 100 Professional Bldg. Hagerstown Md. Date signed 15 April 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 18 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

01419 7

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Clearspring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wilson District
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George R. Morgret

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gladys V. Morgret
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1889

8. AGE: Years	Months	Days	If less than one day
57	11	12	hrs. min.

9. Birthplace: Washington County, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Merchant

FATHER
12. Name: Silas Morgret
13. Birthplace: Penna.

MOTHER
14. Maiden name: Nancy Mc Kee
15. Birthplace: Penna.

16. Informant: Mrs. Gladys Morgret
Address: Clearspring, Maryland, Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 7, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Grove Cemetery
Location: Dot, Pennsylvania.

18. Funeral director: Snyder & Rowland
Address: Clearspring, Maryland.

19. Apr. 7. 1947 (Date rec'd by registrar) Charles H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 4 19 47 at 6:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 19 46, to APRIL 4 19 47
and that I last saw him alive on APRIL 4 19 47

Immediate cause of death	DURATION
Myelo Fibrotic Anaemia	6 mos.
Due to Myelo-fibrotic anaemia.	
Urinary Bladder Hemorrhage due to the anaemia. Not due to cancer.	
Other conditions URINARY BLADDER hemorrhage	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: Hemorrhage Urinary bladder Date of op. April 3. 1947
Autopsy results: Anaemia - Fibrosis marrow (bone)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Archie Robert Allen M. D. or other
Address: Clear Spring Md Date signed: 4-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1947

01420

MARYLAND STATE DEPARTMENT OF HEALTH .

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

Reg. Dist. No. 301

Dr. Young

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Washington

City or town: Kemps. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years.

Hospital, institution, or street address where death occurred:
Hagerstown Md. R. 2

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Kemps Mill - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hagerstown Md. R. 2.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Mary Elizabeth Moser

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel E. Moser

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 19, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	8	____ hrs. ____ min.

9. Birthplace: Near Boonsboro Washington Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home.

FATHER
12. Name: Simon P. Summers
13. Birthplace: Near Myersville Frederick Co. Md.

MOTHER
14. Maiden name: Emmaline Koogle
15. Birthplace: Near Myersville Frederick Co. Md.

16. Informant: Grover E. Moser
Address: Hagerstown Md. R.2

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29 1947 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm. J. Bart and Sons

Address: Boonsboro Md.

19. 4/29 1947 E. Lee McElroy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1947, at 2.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/17/47 19__ to 4/27/47 19__ and that I last saw her alive on 4/27/47 19__

	DURATION
Immediate cause of death: Bronchial Pneumonia	1 Day
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: C. F. Young M. D. or other

Address: Williamsport Md. Date signed: 4/27/47

RECEIVED
MAY 2 1947
BUREAU OF S.

Dr. Porterfield 31

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01421

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
436 Virginia Ave.
How long in hospital or institution? 0--

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 436 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME JESSE THEADORE MOUSE

3. (b) Social Security Number 705-10-4658

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Olive
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) November 9,1885

8. AGE: Years	Months	Days	If less than one day
61	5	13	-- hrs. -- min.

9. Birthplace Clearspring, Washington Co. Md. (Town, county, and state)
10. Usual occupation Mechanic
11. Industry or business Western Maryland Railway
FATHER 12. Name William Martin
13. Birthplace Clearspring Md.
MOTHER 14. Maiden name Martha Mouse
15. Birthplace Clearspring Md.
16. Informant Mrs. Olive Mouse
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/47 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. Apr. 24, 1947 (Date rec'd by registrar) Clark H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1947, to April 22 1947
and that I last saw him alive on April 22 1947
Immediate cause of death Coronary Thrombosis — DURATION 4/22/47
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H B Porterfield M.D. M. D. or other
Address 136 W Washington Date signed 4/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
APR 26 1947
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20

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-L)

CERTIFICATE OF DEATH

01422

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown Rural D 5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Leitersburg Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Leitersburg Pike
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Charles Mundey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth V. Mundey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	8	hrs. min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Minister

11. Industry or business

FATHER
12. Name: Charles Mundey
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Amanda Johnson
15. Birthplace: Washington Co., Md.

16. Informant: Mrs. Ruth V. Mundey
Address: Hagerstown, Md. R D 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 14, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Apr. 14, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1947 at 11:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1947 to April 11 1947
and that I last saw h[illegible] alive on April 11 1947

Immediate cause of death	DURATION
Cardiac dilitation	4/11/47
myocarditis chr.	?
Due to arteriosclerosis generalized	?
Due to	
Other condiitons	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. L. Porterfield M.D.
M. D. or other
Address: 136 W Washington Date signed: 4/12/47

RECEIVED
APR 16 1947
BUREAU [illegible]

18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01423

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Big Springs, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural Big Springs
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bessie B. Murray

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George W. Murray
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	6	..... hrs. ..... min.

9. Birthplace: Washington County, Maryland. (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business

FATHER
12. Name: Bowers
13. Birthplace: New York

MOTHER
14. Maiden name: Boyers
15. Birthplace: Maryland

16. Informant: Jesse J. Murray
Address: Big Springs, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1947 (month) (day) (year)
Cemetery or crematory: Shanktown Cemetery
Location: Near Shanktown, Maryland.

18. Funeral director: Snyder-Rowland
Address: Clear Springs, Maryland.

19. Apr. 12, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1947 at 1:55 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 29 1947, to April 9 1947
and that I last saw h. EQ alive on April 9 1947

Immediate cause of death	DURATION
Coronary occlusion, acute	3 hrs.
Due to: Pulmonary Tuberculosis,	?
Due to: Chronic Fibroid	?
Due to: Chronic Bronchitis	?
Due to: MALNUTRITION	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op. None.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Leslie Robert Colen M. D. or Coroner
Address: Clear Spring, Md. Date signed: 4/10/47

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APR 15 1947
BUREAU

27

01424

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Rural Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Leitersburg District
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Washington
City or town Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Smithsburg #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Catherine Mae Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife David L. Myers
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 10, 1907

8. AGE: Years	Months	Days	If less than one day
40	0	8	hrs. min.

9. Birthplace Washington Co. Md. (Town, county, and state)
10. Usual occupation Home work.
11. Industry or business

FATHER
12. Name D. Walter Bayer
13. Birthplace Washington Co. Md.

MOTHER
14. Maiden name Anna Heddle
15. Birthplace Edgemont, Md.

16. Informant David L. Myers
Address Smithsburg Md. R.R. #2.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/20/47 (month) (day) (year)
Cemetery or crematory Leitersburg Lutheran Cemetery
Location Leitersburg Md

18. Funeral director Walter H. Gunn
Address Waynesboro Pa

19. April 18, 47 (Date rec'd by registrar) C. Scott Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 7 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1925, to Apr. 17 1947
and that I last saw h alive on Apr. 13 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	Instant.
Due to Chronic arterio -	
Due to sclerotic nephritis	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wallis Hamilton M.D.
M. D. or other
Address Waynesboro Pa Date signed April 18-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01425

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or Institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 50 West Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: James F. Newcomer

3.(b) Social Security Number: 217-10-3228

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): May 13, 1904

8. AGE: Years	Months	Days	If less than one day
42	11	5	... hrs. ... min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Cabinet Maker

11. Industry or business: M. P. Moller & Co.

FATHER
12. Name: Harry Newcomer
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Bessie Born
15. Birthplace: Hagerstown, Maryland

16. Informant: Mrs. Bessie Newcomer
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-21-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Apr. 21, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/18/47, 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/11/47, 19..., to 4/18/47, 19...
and that I last saw h... alive on ..., 19...

	DURATION
Immediate cause of death	
Causes of Liver	2 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: H. Eichelberger M.D. M. D. or other

Address: Hagerstown Md. Date signed: 4/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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APR 23 1947
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01426

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
844 S. Potomac Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 844 S. Potomac St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth S. Parks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph A. Parks
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 22, 1869

8. AGE: Years	Months	Days	If less than one day
77	10	22	____ hrs. ____ min.

9. Birthplace: Washington County, Md.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business:

FATHER
12. Name: Lewis Semler
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Sophia Rupp
15. Birthplace: Germany

16. Informant: J. A. Parks
Address: 844 S. Potomac St Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 16, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Apr. 16, 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 13-47 Midnight (hour) at ____ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 26 1945, to 4/13 1947 and that I last saw h[er] alive on 4/13 1947

Immediate cause of death	DURATION
Cardiac dilitation	4/13/47
Myocarditis Chr.	?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: H. S. Porterfield M.D. M. D. or other
Address: 136 W Washington Date signed: 4/14/47

RECEIVED
APR 18 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

01427

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. #17 W. Potomac St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie V. Neikirk Reichter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward Reichter
6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): Dec 141873

8. AGE:

Years	Months	Days	If less than one day
74	4	5	hrs. min.

9. Birthplace: Hyuetts Md
(Town, county, and state)

10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: Michael Neikirk
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah King
15. Birthplace: Maryland

16. Informant: Charles Reichter
Address: Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 1947 (month) (day) (year)
Cemetery or crematory: Riverview Cem
Location: Williamsport Md.

18. Funeral director: Edith V. Leaf
Address: Williamsport Md.

April 22 1947 Mrs E Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947 at 5 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to April 19 1947 and that I last saw h... alive on April 19 1947

Immediate cause of death	DURATION
Hepatic Cirrhosis	4 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or other
Address Williamsport Md. Date signed 4/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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APR 23 1947
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Dr. Poole 12

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

01428

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution? 3 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Boonsboro R# 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt. Lena Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: CONDON ROBINSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 23, 1889

8. AGE: Years	Months	Days	If less than one day
58	0	16	-- hrs. -- min.

9. Birthplace: Lexington, Rockbridge Co. Va. (Town, county, and state)
10. Usual occupation: Had physical handicap
11. Industry or business:
FATHER — 12. Name: Joseph T. Robinson
13. Birthplace: Lexington Va.
MOTHER — 14. Maiden name: Ella Mary Vest
15. Birthplace: LexingtonVa.
16. Informant: Alfred L. Robinson
Address: HagerstownMd.
17. Removal (Burial, cremation, or removal, Which?) Date thereof 4/11/47 (month) (day) (year)
Cemetery or crematory: Colliers town Cemetery
Location: Lexington Va.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Apr. 2, 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1947, at 6 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947 to Apr 9 1947 and that I last saw h.. alive on Apr. 2 1947

Immediate cause of death	DURATION
Hypertension	
Due to Cardio-vascular renal disease	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Ernest J. Lyon M.D. M. D. or other
Address: Hagerstown Md. Date signed 4/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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APR 11 1947
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1865 Noble 33

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (460)

CERTIFICATE OF DEATH

01429

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Cheswold (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Washington
City or town Smithsburg (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henery C. Russman

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Lillie Ann Braun
6.(c) If alive, give age: May 1. years
7. Birth date of deceased (mo., day, yr.): May 1 1864
8. AGE: Years 82 Months 11 Days 23 If less than one day ... hrs. ... min.
9. Birthplace: Garfield Frederick Co. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Self
FATHER 12. Name: Jacob Russman
FATHER 13. Birthplace: not known
MOTHER 14. Maiden name: Elizabeth Green
MOTHER 15. Birthplace: Not known
18. Informant: Clarence Russman
Address: Arlington N.J.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/27/47 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery
Location: Smithsburg Md
18. Funeral director: Walter G Grove
Address: Waynesboro Pa
19. Apr 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to April 27 1947 and that I last saw h... alive on April 27 1947

	DURATION
Immediate cause of death: Carcinoma of Lung	3 days
Due to: Carcinoma of Prostate	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE G. G. Stokes M. D. or other
Address Smithsburg Date signed 4/25/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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APR 28 1947
BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01430

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 1 wk.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Franklin
City or town: Waynesboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Simon L. Sheffler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	W.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1855

8. AGE:

Years	Months	Days	If less than one day
91	5	10	hrs. min.

9. Birthplace: Waynesboro, Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: George L. Sheffler
13. Birthplace: Waynesboro Pa.

MOTHER
14. Maiden name: Catherine Miller
15. Birthplace: Waynesboro Pa.

16. Informant: Mrs. John Lillard
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/9/47 (month) (day) (year)
Cemetery or crematory: Greenhill Cemetery
Location: Waynesboro Pennsylvania

18. Funeral director: Walter J. Grove
Address: Waynesboro Pa.

19. Apr. 8, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1947, to April 6, 1947 and that I last saw him alive on April 6, 1947

Immediate cause of death	DURATION
Myocarditis, chronic	2
Due to: Bronchial asthma	?
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: none
Date of op.: none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Leslie R. Beer Cohen M. D. another
Address: Clear Spring Md. Date signed: 4/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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APR 10 1947
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01431

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73 Years
Hospital, institution, or street address where death occurred: Washington Co Hospital
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: County
City or town: Rural - nr. Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gertie V. B. Shupp

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Clarence E Shupp
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1873

8. AGE:	Years	Months	Days	If less than one day
	73	5	11	hrs. min.

9. Birthplace: Washington Co Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Jacob Stouffer
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Gessard
15. Birthplace: Maryland
16. Informant: Clarence E Shupp
Address: 39 East Ave Hagerstown
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 6, 1947 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.
18. Funeral director: L. F. Reecher
Address: Funkstown, Md.
19. Apr. 5, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3rd 1947, at 3.05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29th 1947, to April 3 1947
and that I last saw h.. alive on April 3 1947

Immediate cause of death	DURATION
Pneumonia - influenzal	5 days
Due to	
Due to	
Other conditions: Arteriosclerosis - Senile	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos J Bateman M.D.
M. D. or other
Address: 1594 W. Washington St Date signed: 4/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 167

CERTIFICATE OF DEATH

01432

Reg. Dist. No. 300

1. PLACE OF DEATH:

County: Washington

City or town: Sharpsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wash.

City or town: Chestnut Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Irvin Theodore Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1947

8. AGE:

Years	Months	Days	If less than one day
	3	14	..... hrs. ..... min.

9. Birthplace: Chestnut Grove-Wash.-Md

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Melvin Mayberry Smith

13. Birthplace: Chestnut Grove-Maryland

MOTHER

14. Maiden name: Edna Irene Kesnor

15. Birthplace: Keyser, W. Va.

16. Informant: Mr. M. M. Smith

Address: Chestnut Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1947 (month) (day) (year)

Cemetery or crematory: Samples Manor

Location: Dargon, Maryland

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md.

19. 4-21 1947 (Date rec'd by registrar) Ed. J. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1947 to April 19 1947

and that I last saw h... alive on April 19 1947

Immediate cause of death: Bronchopneumonia — DURATION

Due fo...

Due to...

Other conditions: Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. L. Bradley M. D. or other

Address: Hagerstown, Md. Date signed 4/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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Dr. Wellss 26

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

01433

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Funkstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
Baltimore St.
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MRS. MOLLIE MISSOURI SMITH

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Lee Smith
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): February 14, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	2	--- hrs. --- min.

8. Birthplace: Fairplay, Washington Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Hezekiah Mongan
13. Birthplace: Fairplay Md.
MOTHER 14. Maiden name: Alice Rebecca Daugherty
15. Birthplace: Fairplay Md.
16. Informant: Mrs. Chester C. Knepper
Address: Funkstown
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/18/47 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Apr. 18. 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1947 at 11:30A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to 4-16 1947
and that I last saw h-- alive on 4-16 1947

Immediate cause of death	DURATION
chr. vascular hypertension	8yrs
Due to chr. myocardial heart disease	6yrs
Due to cerebral thrombosis	2 d.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. Robert Mello M.D.
Address: Hagerstown, Md. Date signed: 4/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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Dr. Ditto 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-d)

CERTIFICATE OF DEATH

D1434

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
Homewood Virginia Ave
How long in hospital or institution? 2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Downsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ---
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: MISS MARY V. SNYDER

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 4 1887

8. AGE: Years	Months	Days	If less than one day
60	0	20	...hrs. ...min.

9. Birthplace: Downsville Wash. Co. Md. (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: Own Home
FATHER 12. Name: Simon Snyder
FATHER 13. Birthplace: Downsville Md.
MOTHER 14. Maiden name: Mary LeFevre
MOTHER 15. Birthplace: Downsville Md.
16. Informant: Rev. W.R.Hartzell
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/26/47 (month) (day) (year)
Cemetery or crematory: River View Cemetery
Location: Williamsport Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Apr 26, 1947 (Date rec'd by registrar) Edward J. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1947 19..., at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1- 1946 to April 24 1947
and that I last saw him alive on April 24-47 1947
Immediate cause of death: Chr Myocarditis — Duration: 6 yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md. Date signed 4/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-2)

CERTIFICATE OF DEATH

01438

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 Years
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? ½ Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 34 North Foundry Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John MArtin Stains

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hilda May Stains
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 30, 1895

8. AGE: Years	Months	Days	If less than one day
51	9	6	..... hrs. ..... min.

9. Birthplace: Greencastle, Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation: Employee Victor Products
11. Industry or business:
FATHER 12. Name: Samuel F. Stains
13. Birthplace: Penna.
MOTHER 14. Maiden name: Catherine Schydtz
15. Birthplace: Penna.
16. Informant: Harry M. Stains
Address: 906 Landvale St. Hagerstown, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 8, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Grove Cemetery
Location: Greencastle Penna.
18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Maryland.
19. Apr. 8. 1947 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947 19 2:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1947, to April 6 1947 and that I last saw h. alive on April 6 1947

Immediate cause of death: Congestive Heart Failure — DURATION: 24 hrs.
Due to: unknown cause
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. D Layman, M.D. M. D. or other
Address: 100 Professional Arts Bldg Hagerstown, Md. Date signed: 7 April 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01435

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: WASHINGTON
City or town: HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred: WASHINGTON COUNTY HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: WASHINGTON
City or town: HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 33 W. WILSON BLVD.
(If rural, give LOCATION)
2.(a) If veteran, name war: NON-VET.

3.(a) FULL NAME: RANKIN AMES STOUFFER

3.(b) Social Security Number: 214-09-8702

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband~~ or wife: SUSAN STERLING STOUFFER
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): FEBRUARY 17, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	9	..... hrs. ..... min.

9. Birthplace: CAVETOWN, WASH., MARYLAND (Town, county, and state)
10. Usual occupation: SHEET METAL WORKER
11. Industry or business: SAND BLAST EQUIP. MANUFACT.
FATHER — 12. Name: WILLIAM H. STOUFFER
13. Birthplace: SHIPPENSBURG, PA.
MOTHER — 14. Maiden name: LILLIE V. SIGLER
15. Birthplace: SMITHSBURG, MARYLAND
16. Informant: Susan I. Stouffer
Address: 33 W. Wilson Blvd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/9/47 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md.
18. Funeral director: Woodford L. Forquer
Address: Hagerstown, Md.
19. Apr. 8, 1947 (Date rec'd by registrar) C. Hastings Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947, at 3:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26, 1945, to April 5, 1947, and that I last saw him alive on April 5, 1947.

Immediate cause of death	DURATION
Meningitis; ~~probably tuberculous~~ Beta hemolytic streptococcic infection. C.W.G.	unknown
Due to:	
Due to:	
Other conditions: Adenocarcinoma left nasal passage & left antrum	about 2 years

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. Hamilton Smith M. D. or coroner
Address: Hagerstown, Maryland Date signed: Apr. 7, '47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Months
Hospital, institution, or street address where death occurred:
Western Pike
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Western Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MELVILLE STEWART SWORD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): June 15 1868

8. AGE: Years	Months	Days	If less than one day
78	10	3	hrs. min.

9. Birthplace: Claylick Franklin Co. Pa. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: David R. Sword
13. Birthplace: Blairs Valley Pa.
MOTHER 14. Maiden name: Christine Bohrer
15. Birthplace: Blairs Valley Pa.
16. Informant: Howard Sword
Address: Hagerstown Md. R # 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/20/47 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Clears Springs Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Apr. 19 19 47 (Date rec'd by registrar) Chas H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-17-47 19 to 4-18-47 19 and that I last saw him alive on 4-18-47 19

Immediate cause of death	DURATION
La Grippe	one week
Due to: Bronchial Pneumonia	two days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Ditto M. D. or other
Address: Hagerstown Md. Date signed: 4/19/47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

1437

Reg. Diat. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Years

Hospital, Institution, or street address where death occurred:

E. Cleveland Ave.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. E. Cleveland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: ALEXANDER TRACEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lucy B. Tracy

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): February 6, 1865

8. AGE: Years	Months	Days	If less than one day
81	4	0	-- hrs. -- min.

9. Birthplace: Claylick, Franklin Co. Penna. (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Own Employer

FATHER

12. Name: James E. Tracy

13. Birthplace: Claylick Pa.

MOTHER

14. Maiden name: Mary B. Tosten

15. Birthplace: Claylick Pa.

16. Informant: Mrs. Lucy Tracy

Address: Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/8/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md,

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Apr. 7, 47 (Date rec'd by registrar) Chas. H. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1947, to April 6 1947 and that I last saw h. alive on April 3 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	11 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. H. Bowers MD M. D. or other

Address: Hagerstown Md Date signed 4/7/47

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